# DEPARTMENT OF THE AIR FORCE

**HEADQUARTERS 5TH MEDICAL GROUP (AFGSC)**
**MINOT AIR FORCE BASE, NORTH DAKOTA**

MEMORANDUM FOR MEDICAL / DENTAL CARE PROVIDER

FROM: 5th Medical Group/SGOQ
10 Missile Avenue
Minot AFB, ND 58705

SUBJECT: Release of Medical Information

This person works in a sensitive duty position at Minot Air Force Base, ND. Please provide us the following information: **diagnosis, medications (to include name, strength, complete directions, and number/amount dispensed), and your recommended treatment plan.** Please enter this information below and have the **patient return the form immediately upon completion of his/her appointment**. In the event he/she would require admission to a civilian hospital, please contact the 5th Medical Group PRP office at (701) 723-5190 or Ambulance Service at (701) 723-5627, in addition, please fax a copy to (701) 723-5391.

Medical Information:

Chief Complaint:_____
_____
Diagnosis:_____
_____
Medication:_____
_____
Any Limitation:_____
_____

_____/_____-_____ _____
Name of Civilian Provider / Phone Number Signature of Civilian Provider

I, _____, request release of the above information to the 5th Medical Group
Patient's Printed Name
upon completion of this medical visit or episode of care. This information is required for me to continue working in my sensitive duty position.

_____/_____ _____-_____-_____
Patient's Signature / Date Social Security Number

"PRP"

| HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
|---|---|
| | |
| DATE:_____ | IS PRP REPORTING REQUIRED? **YES/NO**<br>IF YES, WHAT FUNCTIONAL IMPAIRMENT IS EXPECTED? |
| | **RTS-DT** |
| | TYPE OF MEDICATION PRESCRIBED:_____ |
| | DURATION:_____ UNIT:_____ |
| | CONTACTED:_____ DUTY PHONE:_____ |
| | DATE:_____ |
| | NOTIFICATION MADE BY:_____ |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

| | |
|---|---|
| **RECORDS MAINTAINED AT:** ▶ | **5 MDG/SGOQ**<br>**Minot AFB, ND 58705** |

| PATIENT'S NAME *(Last, First, Middle Initial)* | | SEX |
|---|---|---|
| RELATIONSHIP TO SPONSOR<br>Self | STATUS<br>AD/TG/AGR/CIV | RANK/GRADE |
| SPONSOR'S NAME<br>Self | | ORGANIZATION |
| DEPART./SERVICE<br>AF | SSN/IDENTIFICATION NO.<br>20/ | DATE OF BIRTH |

(Version: April 2011, supersedes June 2010)



**STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505